

Collin County Community Supervision & Corrections Department
Financial Profile

Defendant's Name: _____

Total Household Income: _____ Number in Household: _____

Step 1 - List your monthly income

Monthly Income \$ _____
Hourly \$ _____
Net Income \$ _____
Net Spouse \$ _____
Support \$ _____
Welfare \$ _____
Food Stamps \$ _____
Social Security \$ _____
VA \$ _____
Other Income \$ _____

(A) TOTAL INCOME \$ _____

Step 2 - List your monthly expenses

Mortgage \$ _____
Rent \$ _____
Utilities \$ _____
Phone \$ _____
Food \$ _____
Trash \$ _____
Pub Service \$ _____
Auto Gas \$ _____
Auto Loan \$ _____
Auto Insurance \$ _____
Auto Repairs \$ _____
Clothing \$ _____
Doctor \$ _____
Medical Insurance \$ _____
Child Care \$ _____
Child Support \$ _____
Personal Loan \$ _____
Credit Cards \$ _____

(B) TOTAL \$ _____

(C) Court Ordered Payments \$ _____

(Other 1)

Laundry & Dry Cleaning \$ _____
Barber & Beauty Shop \$ _____
Cosmetics & Misc Toiletries \$ _____
Cigarettes/tobacco \$ _____
Vacation/Christmas \$ _____

(D) TOTAL \$ _____

(Other 2)

Life Insurance \$ _____
Donations \$ _____
Recreation/alcohol \$ _____
Savings \$ _____
Renters Insurance \$ _____

(E) TOTAL \$ _____

(Other 3)

Newspapers/magazines \$ _____
Tuition \$ _____
Books/supplies/stationery \$ _____

(F) TOTAL \$ _____

(Other 4)

Big Purchases \$ _____
Other Install Payments \$ _____

(G) TOTAL EXPENSES \$ _____

(Add totals from B, C, D, E, & F)

TOTAL INCOME \$ _____

(Total from A)

TOTAL EXPENSES \$ _____

(Total from G)

DISPOSABLE CASH \$ _____

Assets

Stock Value \$ _____
Bond Value \$ _____
Certified Deposits \$ _____
Savings Account \$ _____
Other Assets (specify) \$ _____

What is your means of support? _____

VERIFIABLE DOCUMENTATION MUST ACCOMPANY THIS FORM

A person may still qualify for contract services despite income being higher than the threshold if they can show extraordinary expenses. In those cases, please complete a full financial profile.

By my signature below, I certify that the information given above is true and accurate to the best of my knowledge. I understand that, if I have falsified my income, I may be required to reimburse the CSCD for any funds spent on my evaluation and/or treatment.

Defendant

Date

Supervision Officer

Date